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86-1.84 Supplementary Low Income Patient Disproportionate Share Adjustment.

(a) The [~~rates of~~]payment for the periods between January 1, 1991 through July 31, 1991 and August 1, 1991 through [~~December 31, 1995~~] **June 30, 1996** for persons eligible for federal financial participation under title XIX of the federal Social Security Act in medical assistance paid by State governmental agencies pursuant to Title 11 of Article 5 of the Social Services Law, shall include for eligible general hospitals a supplementary low income patient disproportionate share adjustment determined pursuant to subdivision (b) of this section. **The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.**

(b) The supplementary low income patient adjustment shall be determined by multiplying the applicable supplemental percentage coverage of need amount for the hospital as specified in paragraph (2) of this subdivision by the hospital's need as defined in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data for the period January 1, 1991 through December 31, 1993 and calculated using 1991 data for public hospitals, voluntary non-profit or private proprietary general hospitals for the period January 1, 1994 through [~~December 31, 1995~~] **June 30, 1996**. This amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable costs and divided by the service units of those Medicaid patients eligible for Federal financial participation under Title XIX of the federal Social Security Act in medical assistance pursuant to Title 11 of Article 5 of the Social Services Law, to arrive at the supplementary low income patient disproportionate share adjustment per unit of service.

(1) The low income patient percentage shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical

assistance pursuant to Title 11 of Article 5 of the Social Services Law, inpatient discharges of self pay patients* and inpatient discharges of charity care patients divided by total patient discharges expressed as a percentage. The percentages for the period January 1, 1991 through December 31, 1993 shall be calculated based on base year 1989 data from the statewide planning and research cooperative system (SPARCS), which was received by the Department no later than November 1, 1990. The percentages for the period January 1, 1994 through [~~December 31, 1995~~] **June 30, 1996** shall be calculated based upon 1991 data from the statewide planning and research cooperative systems (SPARCS), which was received by the Department no later than November 1, 1993.

***NOTE:** **Self-pay patients represent patients who are uninsured and who are not full pay patients**

(2)(i) The scale utilized in the development of a hospital's supplementary low income patient disproportionate share adjustment for the period January 1, 1991 through June 30, 1991 shall be as follows:

Low Income Patient Percentages	**Supplemental Percentage Coverage of Need**
50+ to 55%	5.0%
55+ to 60%	10.0%
60+ to 65%	15.0%
65+ to 70%	22.5%
70+ to 75%	30.0%
75+ to 80%	37.5%
80+	45.0%

(ii) The scale utilized for development of a hospital's supplementary low income patient adjustment for the period August 1, 1991 through [~~December 31, 1995~~] **June 30, 1996** for a public hospital and August 1, 1991 through September 30, 1992 for a voluntary non-profit or a private proprietary general hospital shall be as follows:

Low Income Patient Percentages	**Supplemental Percentage Coverage of Need**
35+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+%	45%

(iii) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period October 1, 1992 through March 31, 1993 and for the period January 1, 1994 through [~~December 31, 1995~~] **June 30, 1996** shall be as follows:

Low Income Patient Percentage	**Supplemental Percentage Coverage of Need**
35+ to 50%	10%
50+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+	45%

For the period January 1, 1994 through [~~December 31, 1995~~] June 30, 1996 if the sum of the adjustments pursuant to this subparagraph would exceed $36,000,000 for a rate year, the supplemental percentage coverage of need scale pursuant to this subparagraph shall be reduced on a prorata basis so that the sum of such adjustments provided for the rate year shall not exceed $36,000,000.

(iv) The scale utilized for development of a voluntary non-profit or private proprietary general hospitals' supplementary low income patient adjustment for the period May 15, 1993 through December 31, 1993 shall be at 120% of the supplemental percentage coverage of need scale specified in paragraph (2) (ii) of this section.

(3) The supplementary low income adjustment shall be limited for rate periods during January 1, 1991 through December 31, 1993 such that this amount, when added to the distribution determined pursuant to subdivision (d) of section 86-1.65 of this Subpart for the rate period, plus for a major public general hospital, the amount of any supplementary bad debt and charity care disproportionate share payments determined pursuant to section 86-1.74 for the rate period shall not exceed 90 percent of need as described in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data. In addition, in order to be eligible for an adjustment pursuant to this section, the hospital shall not be eligible for distributions as a financially distressed hospital pursuant to section 86-1.65(d)(3) of this Subpart and the hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(c) The supplementary low income patient disproportionate share adjustment provided in accordance with this section for rate periods during January 1, 1991 through December 31, 1993 shall be adjusted to reflect actual distributions made pursuant to subdivision (d) of section 86-1.65 of this Subpart and section 86-1.74 of this Subpart and actual service units as defined in subdivision (b) of this section.

provided to beneficiaries of title XVIII of the Federal Social Security Act and excluding direct medical education costs.

(b) [~~$33 million shall be allocated for technology advances and changes in medical practice. Amounts allocated to each general hospital shall be based on a fixed amount per bed determined by multiplying the number of certified inpatient beds for each general hospital as of June 30, 1990 by the result of dividing the $33 million by the sum of the certified inpatient beds for all general hospitals.~~]

(c) $26 million shall be allocated to costs of general hospitals based on the costs incurred in excess of the trend factor between 1985 and 1989 in the following discrete areas: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast media, malpractice costs, water and sewer charges, ambulance costs, service contracts, prosthetic and orthotic devices and costs related to designation as a trauma center and contracted nursing services.

(1) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for each discrete area for all general hospitals is greater than or equal to $26 million, the $26 million shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1989 costs incurred in excess of the trend factor in such discrete areas, summed, to the total sum of such cost over trend of all general hospitals.

(2) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for all general hospitals is less than $26 million, the allocated costs to each general hospital

(DRGs) 475,483,540, 701-716 and 798-801.

(b) $63 million shall be allocated to general hospitals for labor adjustments. Such amount shall be allocated as follows:

(1) An amount equal to $55 million shall be allocated for labor cost increases incurred prior to June 30, 1993. Amounts allocated to each general hospital shall be based on the general hospital's share of the statewide total of inpatient and outpatient reimbursable operating costs based on 1990 data excluding costs related to inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54 (g) (3);

(2) An amount equal to $8 million shall be allocated for labor adjustments to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each general hospital determined pursuant to this subclause shall receive a portion of the $8 million equal to the general hospital's portion of the total inpatient and outpatient reimbursable operating costs based on 1990 data for all hospitals located in the counties identified pursuant to this subclause, excluding costs related to services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54(g)(3).

(c) [~~$55 million shall be allocated for increased activities related to regulatory compliance universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which each hospital is certified as of August 24, 1993.~~]

(d) An amount equal to $3 million shall be allocated to the costs of each general hospital in the following manner and which meet the following criteria:

(1) $250 per bed shall be allocated to the costs of each general hospital having less than 201 certified acute care beds as of August 24, 1993 and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (D) or defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (d) or defined as a rural hospital under section 700.2 (a) (21) of

other payments specified elsewhere in this section if the patient is a transfer patient as defined in section 86-1.50(j) of this Subpart.

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to all DRG case-based rates of payment calculated pursuant to paragraph (1) of this subdivision, and to rates or supplemental payments made pursuant to paragraph (3) of this subdivision.

(i) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(ii) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) For the period July 1, 1995 through June 30, 1996 the Commissioner shall increase the rate of payment, in the aggregate by an amount not to exceed seventy-five million dollars for those voluntary non-profit and private proprietary general hospitals which qualify for distributions as a financially distressed hospital pursuant to section 86-1.66 of this Subpart and that requested designation as such before February 1, 1995 or qualify for the supplementary low income patient adjustment in accordance with section 86-1.84 of this Subpart. The rates will be increased as follows:

(i) $18.75 million shall be allocated among such hospitals which have an outstanding debt obligation to the New York State medical care facilities finance agency or its successor, as an eligible secured hospital borrower and any hospitals which qualify for distributions as financially distressed hospitals in accordance with section 86-1.66 of this Subpart with a negative fund balance in excess of $50 million dollars as of December 31, 1994, based on the estimated proportionate impact for each such hospital compared to all such hospitals of the reductions in payments by state governmental agencies for hospital inpatient services through June 30, 1996, as contained in a chapter of the laws of 1995, specifically New York State's Public Health Law, enacting cost containment provisions for the Medical assistance program.

program. Any remaining amount not allocated by March 31, 1996 according to this subparagraph shall be allocated according to clause (c) of subparagraph (ii) of this subdivision.

(iv) Allocations pursuant to this subdivision shall be based on general hospital classifications as of April 1, 1995.

(b) Exempt hospitals and units. Payments to hospitals for acute care services that are exempt from DRG case-based payment rates shall be established pursuant to section 86-1.57 of this Subpart. The hospital specific costs identified in subparagraph (a)(1)(ii) of this section shall be apportioned to the exempt unit operating per diem based on the data provided by the hospital. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(1) For the period April 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(2) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58

(c) Alternative level of care payments. Hospitals providing alternative level of care services as defined in section 86-1.50 of this Subpart shall be reimbursed for this care pursuant to the provisions of section 86-1.56 of this Subpart. [~~These payments shall include a health care services allowance~~]

(1) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(2) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(3) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

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86-1.54 Development of DRG case-based rates of payment per discharge. (a) The hospital-specific average reimbursable inpatient operating cost per discharge shall be determined by dividing hospital-specific non-Medicare reimbursable operating costs determined pursuant to paragraph (1) of this subdivision by non-Medicare discharges determined pursuant to paragraph (2) of this subdivision and dividing this result by the hospital-specific case mix index determined pursuant to paragraph (3) of this subdivision.

(1) Hospital-specific non-Medicare reimbursable operating costs shall be the hospital's 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart including any adjustments made pursuant to section 86-1.52(a)(1)(iii)(a)(iv), and (v) of this Subpart but excluding the following costs:

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) transfer costs as defined in subdivision (f) of this section;

(v) short-stay outlier costs as defined in subdivision (f) of this section; and

(vi) high-cost outlier costs as defined in subdivision (f) of this section.

(vii) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, such administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph, shall mean those base year administrative and general costs remaining after application of all other efficiency standards,

to paragraph (a)(3) of this section. The group average wage and case mix adjusted operating cost per discharge shall be based on hospital-specific reimbursable operating costs which shall be calculated as follows:

(1) The following costs shall be subtracted from the sum of the hospital's allowable 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this subpart and any adjustments made pursuant to section 86-1.52 (a)(1)(iii)(a), (iv), and (v)(a).

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) direct GME costs as defined in subdivision (g) of this section; and

(v) hospital-specific operating costs as defined in subdivision (g) of this section.

(vi) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines.

(2) The hospital-specific portion of the $40 million base enhancement specified in section 86-1.52(a)(1)(iii)(b) of this Subpart shall be added to the costs determined for each hospital in

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Section 86-1.55

Development of Outlier Rates of Payment.

(a) Short Stay Outliers. Payments for short stay outlier days shall be made at a per diem calculated by multiplying the days of actual length of stay below the short stay threshold by the short stay per diem rates defined in this subdivision. The short stay per diem rate shall be determined by dividing the hospital's DRG case-based rate of payment determined pursuant to section 86-1.52(a)(1) by the hospital's group average arithmetic inlier LOS for the DRG and multiplying the result by the short stay adjustment factor of [~~150~~] [100] percent. In cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the short stay adjustment factor shall not be applied. Budgeted capital costs determined pursuant to section 86-1.59 of this Subpart shall be added to the per diem.

(b) Long stay outliers. Payments for long stay outlier days shall be made at a per diem rate calculated by multiplying the days of the actual length of stay in excess of the long stay outlier threshold by [~~60~~] [50] percent of the per diem obtained by dividing the group average DRG operating cost per discharge defined in section 86-1..54 (b) of this Subpart by the hospital's group average arithmetic inlier length of stay for the DRG. This result shall be multiplied by the percent for the group average reimbursable inpatient operating cost determined pursuant to section 86-1.53 of this Subpart. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent of the rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Cost outliers. (1) Cost outlier payments must be requested from the third-party payor.

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86-1.54, of the difference between such cost, and the greater of two times the hospital's diagnosis related group case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1)-(2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(1) of this Subpart or six times the hospital's average DRG case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1) and (2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(1) of this Subpart.

(3) Cost outlier payments shall not be made for cases that qualify as short stay outliers or transfers (other than patients assigned to transfer DRGs). Patients assigned to transfer DRGs may meet the criteria for outlier payments, in which case the limitations set forth in this paragraph shall apply. If during a rate year the payments for high-cost patients made pursuant to this subdivision reach the proportion of high costs calculated pursuant to section 86-1.54(f)(3) of this Subpart, then all additional requested high-cost payments for that rate year, including the inlier DRG case payment rate, shall be pended until the appropriateness of the charge schedule upon which the high costs are determined is reviewed.

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 [~~rate year~~] of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to the cost outlier payments.

(i) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(ii) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Hospitals that have not established ancillary and routine charges schedules shall not be eligible for high-cost outlier payments.

to section 86-1.58 of this Subpart. A capital per diem payment shall be computed on the basis of allowable budgeted capital costs allocated to the unit divided by budgeted days in the unit, reconciled to actual certified capital expense divided by actual days. A [~~primary~~] health care services allowance of:

(1) .614 percent [~~of the hospital's non-Medicare reimbursable inpatient costs~~] for rate year 1994 and .637 percent for [~~rate year~~] the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58;

(2) for the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(3) for the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to the rate. AIDS Centers that do not comply with the provisions of Part 405 of this Title with regard to the provision of inpatient, outpatient community and support services for the screening, diagnosis, treatment, care and follow-up of patients with AIDS shall have their rates of payment prospectively adjusted to reflect services not being provided in accordance with Part 405 of this Title from the time the services were not being provided in accordance with Part 405 of this Title.

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86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provisions of this section.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.

(d) The commissioner shall implement one prospective interim annual adjustment to the trend factors, based on recommendations of the panel, effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors based on recommendations of the panel to be effective on January first, two years after the initial trend factor was established. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

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